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LOCAL DIRECTORY

Medical Society Meetings

MARYLAND

NOTE.—Secretaries are requested to advise us promptly of the election of new officers in their respective Societies, that due announcement may be made in the JOURNAL.

Except where otherwise stated, the Medical Societies of Baltimore meet at the Medical and Chirurgical Faculty building, 1211 Cathedral Street.

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PERITONITIS: REPORT OF 100 CASES.

By Frederic Rankin, M.D.,
Instructor in Surgery in the University of Maryland.

In reporting the following 100 cases occurring in the service of Dr. Frank Martin we have not selected any particular variety of peritonitis, nor excluded any bad cases, but have taken the last 100 cases operated upon as they appear and without regard to either etiology or fatality. The term general peritonitis has been used for some time to define free pus in the peritoneal cavity, without making any comparative attempt to differentiate the degree of contamination. We have classified our cases as localized, diffuse and general, meaning by the latter term that the several fossae of the peritoneal cavity are invaded, and that its whole has been contaminated, whilst by diffuse we mean to convey that a contamination of the general peritoneal cavity is taking place, that infection is spreading, but at the time of operation is confining itself to at least two quadrants of the abdomen, without in any sense being limited by the abscess walls. The term localized, of course, explains itself.

In this series of cases the etiological factors have been as follows:

Gastric ulcer	4
Duodenal ulcer	1
Traumatic ruptured intestine	2
Salpingitis	8
Strangulated, perforated, diverticulum, Meckel's	1
Intestinal obstruction due to gall-stones	3
Tuberculous peritonitis	3
Cholecystitis	3
Appendicitis	75

The bacteriological report on all these cases has not been available, owing to numerous circumstances which occur in every clinic, and hence the detailed report of this side of the question is withheld. However, in five cases of appendiceal origin the pathologists reported streptococcus as the predominating organism and in a great majority of the remaining cases the following: "Colon predominates, but numerous staphylococci are present," was rendered.

and in a number of cases, however, he reported in addition to the colon bacillus and staphylococci that streptococci were also present. In view of the fact that the rapidly growing colon bacillus blots out the other more slowly developing organisms, streptococcus very likely is present in the vast majority of all the cases of peritonitis where the intestinal content is poured into the peritoneal cavity.

In the appeniceal cases the appendix has been post-cecal 11 times, although the peritonitis was general. In 16 cases of appendiceal origin the peritonitis was localized.

The youngest case operated on in this series was two and a half years old, the oldest 65 years old, the majority of the cases occurring between the ages of 20 and 35.

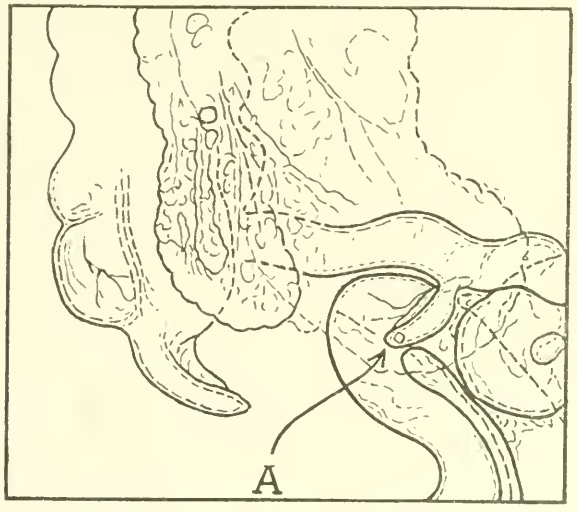

Fig. 1—"A" shows the diverticulum as it lay in position in the abdomen, with adherent intestinal loops and omentum.

Of the four cases lost in this series the etiological factor was as follows:

Tuberculous peritonitis	1
Gastric ulcer	1
Duodenal ulcer	1
Appendix	1

The following seven cases are reported in detail because of their comparative rarity, including as they do three cases of gall-stones which had perforated into intestines and later causing obstruction and peritonitis, peritonitis from a strangulated Meckel's diverticulum and a pneumoccocic infection:

Case 1. That of a child, aged seven years. Patient was taken ill on the morning of November 20th with severe abdominal pain and her family physician, who was called in the following day,

found she had tenderness over the abdomen. He saw her again that evening and found her vomiting, with pain in abdomen and tenderness. Temperature 103. At the time of admission to hospital there was considerable stiffening of the abdominal wall and tenderness, more in right than in left abdomen. Point of greatest tenderness was in the lower abdomen in the region of the appendix. She had been well prior to this, had been up and about and going to school. On the 27th of November the temperature had gone up to 104 1/5, pulse 160. The child looked quite ill. On account of the marked evidence that the trouble was general peritonitis an incision was made through right rectus. As soon as the peritoneum was opened the pus welled out. It came from every quadrant of the abdomen. The appendix was sought and found red and congested, but not perforated. The appendix was removed in the usual manner and the pelvis investigated. A lot of thick pus welled up, some was taken for culture purposes, and a tube placed in the pelvis, along with three rubber tissue iodoform tucks. The abdomen was closed with cat-gut sutures. Skin closed with sub-cutaneous silver wire. An examination of the pus at once showed that a diplococcus (?) was the predominating organism. The patient, after a very stormy convalescence, finally left the hospital in good condition.

Pneumococcus peritonitis occurs most frequently in children, and is being recognized more often than formerly because surgeons are on the lookout for it. The disease was first described by Bozzolo from autopsy findings in 1885 and first operated on by Nelaton in 1890. Annand and Bavin in 1906 collected all cases reported up to that time and found 91 in children under 15 years of age, and that the female sex seemed more invaded than the male. The greater frequency of this condition in females has been attributed to an ascending pelvic infection, in which the peritoneum was infected by way of the open end of the Fallopian tube, just as gonorrheal peritonitis is brought about. There is very little proven in support of this theory. Pneumococcus vulvovaginitis has been very difficult of demonstration in cases of peritonitis due to this organism. Sources and avenues of infection still remain uncertain. There are a number of possibilities: The peritonitis may be a part of the general sepsis; it may be secondary to an infection elsewhere, and the infection may travel along the lymphatics or by planes of tissue by continuity; or the peritonitis may be a primary infection. In support of the latter possibility it must be remembered that the pneumococcus is normally found in the throat and must therefore be swallowed with saliva. Although the organism's growth is inhibited in an acid media, still the stomach contents at times is not acid. Also, an enteritis is rather a constant early symptom of pneumococcus peritonitis, thereby suggesting an infection of the mucous membrane of the intestinal tract, produced by this microorganism. Still further, the pneumococcus has been isolated from an ulcer or Peyers patch. Clinically, the peritonitis is often secondary to a pneumonia,

and in a number of instances autopsy failed to show any involvment of the diaphragm. It is not believed that continuity of tissues plays much part in the involvment of the peritoneum, and opinion is divided as to whether the infection is a hematogenous one or due to ingestion, with perhaps the weight of belief in favor of the blood stream as the carier of infection.

Case No. 2. Obstruction of bowels from gall-stone impaction with general peritonitis. History: He is a farmer, a slender, thinnish man, whose previous history does not seem to be of a personal condition, as far as can be ascertained. He has been moderately well, has had some indigestion, but nothing specific that bears upon the condition found at the time of operation. When first seen he presented a typical picture of acute intestinal

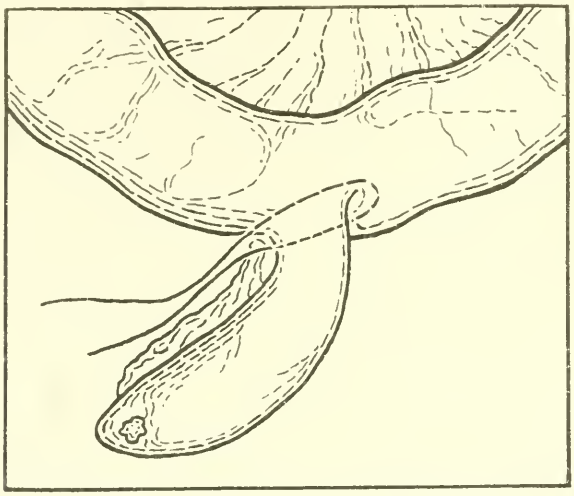

Fig. 2—Shows the diverticulum with the purse-string suture in position.

obstruction, with the entire symptom complex of this, which had existed, so far as could be ascertained, for five days. His symptoms were those of a badly poisoned man. His face was pinched and there was a persistent vomiting of a fecal character, just that gulping vomiting that goes with obstruction. There was more or less persistent pain, active peristalsis, and on inspecting the abdomen it was found enormously distended, with a characteristic Von Wahl's loop carefully mapped out; that is, with an attack of pain-coming-on. Peristalsis was noted, and in the height of peristalsis large distended loops of small intestines could be seen on the abdomen with characteristic ridges between them. Along with this there was a history of being unable to get the bowels open, and in spite of purgation and enemas the obstruction was getting more and more noticeable. He had a small wiry pulse, not very rapid, and with practically no temperature, 99 by rectum. Under ether a large incision was made in the right rectus

muscle, and as soon as the peritoneum was opened a lot of murky serum came up, and then large ballooned loops of small intestines began to bulge through the incision, which was made purposely well to the right in order to gain easy access to the right iliac fossa. A hand was passed down and found a mass, from which ballooned intestines could be seen coming away, and to which the collapsed small intestine could be traced. The intestines were now packed off with Mikulicz pads wrung out in salt solution and the seat of obstruction inspected. Around this mass were a great many adhesions of dense character, which were separated with scissors and knife. After the adhesions were loosened, upon lifting up one loop of intestines which happened to be a portion of the ileum, about six inches from the ileo cecal valve, it was found to have an opening in its lumen and mucous bubbled out. There was no escape of fecal matter from it, however. A purse-string suture was put around it and the opening closed. On continuing to separate the adhesions at this point between apparent coils of intestines, the opening into the lumen of the ulcer was found and a gall-stone revealed. Further separation revealed that there had been an opening made between these two adjacent bits of intestines, being doubtless a laceration from one to the other produced by the gall-stone. In other words, an anastamosis had occurred between these two loops. Further efforts to separate the loops revealed that the loop in which part of the gall-stone was lying was the bulbous end of the appendix, and by freeing the adhesions of the meso-appendix it could be gotten up and clearly demonstrated that the ulceration had taken place between the ileum and the bulbous appendix. By this time the stone had rolled out and a pack of gauze wrung out in salt solution was packed into the intestines to keep its contents from coming out. The appendix was then gotten up at the cecal junction. The piece of ileum that was adherent to the brim of the pelvis was freed, at which point, proximal to the lodgment of the stone, the gut was completely obstructed. It was impossible to do anything with it while down in the pelvis so far, so the adhesions were freed and finally this portion of the ileum was gotten up. A certain amount of fecal matter retained back of this point gushed out. This was quickly packed off and very slight contamination took place. After getting it where it could be worked upon three fixation sutures were put in so as to close the opening promptly. It was at least an inch long and to the side of the bowel rather than its free surface. After getting the mucous membrane inverted, fixation sutures in and the opening fairly well closed with Lembert sutures, the serous surfaces were brought together. This closed the opening nicely, without in any way impinging on the normal lumen of the bowel at this point. After this was finished it was noted that the current in the intestine was re-established and the constricted point opened up nicely. The impression of the bowel was clearly shown and presented the appearance of a piece of bowel which had a thin strip of tape tied around it. The vitality of the tissues was good

and gave the impression that they would recover without difficulty. The pelvis was drained in the usual manner with cigarette tucks of iodiform gauze and a fair-sized rubber-tissue tube, one rubber-tissue tuck was placed down to the point where the intestines had been sutured and the obstruction had been. The abdomen was closed with catgut for the peritoneum and fascia, and fine silk for the skin. The patient was shocked somewhat by the operation, but had a fair pulse. He was given 500 to 700 c. c. of normal salt solution under the breast during the operation, and went off the table in fairly good shape. The operation took one hour and a half, but he reacted nicely and the vomiting stopped, and on the following morning his condition was exceptionally favorable. He had a pulse of 80, temperature normal and drainage free. He was

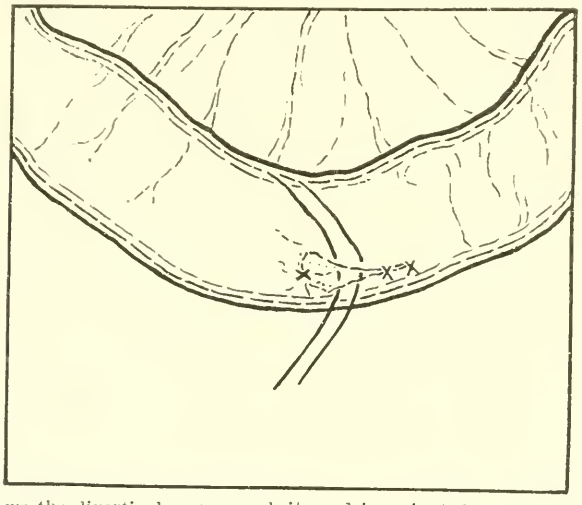

Fig. 3—Shows the diverticulum removed, its end invaginated, and the peritoneum covered over with Lembert sutures.

treated along the line of general peritonitis; that is, the Fowler position, normal salt by rectum, nothing by mouth. Drainage was properly diminished, the abdomen healed nicely and the patient left the hospital on October 29th entirely recovered.

Case No. 3. Intestinal obstruction with peritonitis, due to gall-stones. Patient, Mrs. V. Aged 62. December 14th. Under ether an incision was made through the left rectus and as soon as the abdomen was opened coils of distended small intestine bulged into the wound, and a lot of dark, turbulent, bloody fluid came out of the peritoneal cavity. A search of the abdomen revealed a hard mass in the region of the left iliac fossa and the small intestine. This was gotten into the wound and distal to it the small intestines were all collapsed, proximal, all distended. In endeavoring to ascertain what portion of the small intestine the obstruction was in it was found to be about eight inches from the ileo cecal valve

of the ileum. The rest of the abdomen was packed off with Boston pads wrung out in normal salt and the intestine opened opposite the mesenteric border and a large, impacted gall-stone removed. Quite a little contents of the bowel escaped, and the hole was sutured up with interrupted sutures, taking in all the coats, and then Lembert sutures put over it. The pelvis was drained in the usual manner, the patient treated as all other general peritonitis cases are treated, drainage promptly removed and patient made an excellent recovery.

Case No. 4. Mr. H. P. Aged 27. History: February 11th. This morning he was with his team and the pole of the wagon struck him in the abdomen, giving him a severe blow, and in addition to this he was caught between the pole and hitching post and pressed upon. He was immediately sent into the hospital with violent abdominal pain, vomiting, no temperature, but a stiff abdominal wall. With this history and a diagnosis of possible rupture of the bowel a laparotomy was done. Upon opening his abdomen a lot of thick, purulent exudate poured out, and it was noted that over the intestines lymph poured out and a beginning peritonitis was found everywhere. The patient was disemboweled and the small intestine searched carefully and a small hole on the free border of the ileum, about two feet from the ileo cecal valve opposite the mesenteric attachment, was discovered. The hole would admit the end of a finger and was closed with the Connell suture, longitudinally, and then whipped over with Lembert sutures. Although the rest of the small intestine was carefully examined, no other perforation was found, but a great quantity of exudate and pus existed throughout all the abdomen. The patient was flushed out with normal salt and the lymph washed off, the bowels replaced in the abdomen and pelvis drainage of a tube and two cigarette tucks placed. The wound was closed with cat-gut and silver wire. The patient made an uninterrupted recovery and left the hospital at the end of three weeks.

Case No. 5. Ruptured intestine with general peritonitis. Patient, Mr. W. W. M. Aged 34 years. History: He was playing football two days ago, when he received a blow in the lower abdomen. Five minutes after that he was taken with severe abdominal pain, which was followed by marked stiffening of the abdomen, which persisted. He was brought down to the hospital late last night, having had one-fourth and one-sixth grain of morphia given him. Leucocyte count 23,000. Abdomen board-like. Pulse 110. Very little temperature by mouth, but 101 by rectum, but the board-like abdomen was very pronounced. Upon opening the abdomen it was found to be full of pus, one of the cases of a diffuse, general peritonitis. The hole in the bowel was in the small intestine, some distance from the ileo-cecal valve. The loop was over towards the left side and there was lots of fresh exudate all over the coils of intestines and the fecal contents poured out of the opening. Upon putting the hand in the pelvis about a quart of ill-smelling pus was evacuated. The intestines were packed off with Boston packs

soaked in salt solution. The injured loop was pulled out of the belly and let empty itself. The intestines were pretty well engorged, and there was quite a lot of stuff in the small intestines, due to the fact that he had been given castor oil, calomel, etc. All the contents of the intestines possible was emptied, and the opening, which was about half an inch long, running transversely in the wall of the bowel, in fact, from the mesenteric attachment, was sutured over with a roll of interrupted sutures and covered with three or four Lambert's to bring the serous coats together. A large tube and some cigarette drains were placed in the pelvis and the incision closed with catgut and silver wire. The patient was infused on the table 700 c. c. of normal salt and was very much shocked when the operation was over. Four days later intra-abdominal symptoms seemed better, but he had a gangrenous infection with blush all over the abdominal wall. The wound was laid open, packed with bichloride gauze and hot dressings applied continuously. At the end of ten days the whole picture was better, the wound infection was subsiding, the intra-abdominal symptoms were disappearing, and the patient seemed on the road to recovery. After fighting down this infection the patient made a rapid recovery, and left the hospital at the end of four weeks, but with a very weak abdominal wall, which has later been repaired.

Case No. 6. Mrs. P. Aged 44 years. November 9. History: She has been in bed since November 3. She has had considerable tenderness in lower abdomen and some temperature. On the evening of November 8 her temperature became much higher, reaching 104. For some weeks past there has been a vaginal discharge, profuse and bloody, and the supposition is that she has an infection which started in this way, extending up the tubes, causing peritonitis. Leukocyte count 28,000. A mid line incision was used to open the abdomen, which was very fat and pendulous. The peritoneum was thickened and much inflamed. As soon as it was opened quantities of pus came out. Upon investigating the cause of the trouble, large ballooned pus tubes were found. The leakage had occurred from these, and she had in consequence a gangrenous condition in the pelvis, and any quantity of foul-smelling pus, and general peritonitis. The tube on the right side was as large as two fists, adherent and lying back in the pelvis back of the uterus. Its walls seemed to be gangrenous and the peritoneum to which it was attached by dense adhesions seemed likewise gangrenous. It ruptured in the effort of getting it out and a large amount of pus came out with it. It was gotten up quickly and rapidly sectioned off, clamping off its blood supply. The same condition was found on the left. Although enormous, it was not quite as large as found on the right side, but more adherent and more gangrenous. This was gotten up, clamped off, and gotten away. This left the necrotic uterus, which was taken away, completing the hysterectomy. The stump was closed over it, drainage was put into the pelvis in the usual man-

ner, and the patient returned to bed in a very much shocked condition. She was given the usual treatment for peritonitis and left the hospital entirely healed at the end of three weeks.

Case No. 7. Strangulated, perforated, Meckel's diverticulum with general peritonitis. Mr. V. P. R. Aged 39 years. Operation February 8. History: As far as he knows he was well the day before, but in the early morning of the 8th he had a severe abdominal pain. On account of a certain amount of constipation he had always been accustomed to take some mineral water, and on the coming on this pain he took some of this water but without the usual effect. The pain went on and became more severe, and he took some castor oil and whiskey. He got up after awhile and went down to attend to some business, and towards midday ate some lunch. Then he became nauseated and vomited. He went home about midday and his family physician was called to see him. He had some vomiting, great pain radiating all over abdomen, with tenderness, and with a sore spot to the right of the mid line below the umbilicus. He had been seen by his doctor at 4 o'clock when his pain was so great, and suspecting renal colic, he was given two hypodermics of morphia. At 9 o'clock that night he was brought to the hospital with a leukocyte of 18,000, rectal temperature 102⅘, pulse 108, with a tense, tender abdomen. A diagnosis of profuse peritonitis was made and an immediate operation advised. The advice was accepted and under ether the abdomen was opened through the McBurney incision, and as soon as the peritoneum was opened pus welled out, and investigation through the abdomen showed pus coming from every quadrant. A large thick piece of omentum was adherent to the inguinal canal on the right side, and had to be loosened before the right iliac fossa could be explored. This having been loosened, the appendix was sought and found to be normal. He was very distended and the small intestines kept bulging out, and in their bulging a piece of small intestine came through, which was covered all over with fresh inflammatory exudate and stuck together in coils, and in separating these coils and getting rid of the exudate, bubbles of air came out from apparently one of the coils and a small perforation was found in what looked to be a bit of small bowel. On pulling this up further and separating it, a strangulated Meckel's diverticulum was recognized, having perforated at its end and leakage occurring. It was a short diverticulum, coming off from the small intestines about two and a half feet from the ileo-cecal valve. The omentum was stuck down over this and the coils of intestine immediately around it were stuck together. These were pushed back and packed off. The diverticulum was straightened out, a purse-string suture put around it close to the intestinal wall where it came off. It was somewhat invaginated and a Lembert suture placed over it. Drainage tubes and cigarette tucks were put in the pelvis and the abdomen closed around them in the usual manner. The patient made an uninterrupted recovery and left the hospital on the eighteenth day cured.

Treatment: The treatment of the three stages of peritonitis, namely, prior to operation; second, the operative stage; third, post-operative stage, so markedly differs as to require their consideration separately.

Of the treatment of peritonitis prior to operation it may be said that surgeons within the past decade have done much to simplify and advance it, but in no abdominal condition is such a fine adjustment of judgment, such an insight into existing conditions still necessary in order that the patient may gain every advantage to fight his infection. It is at this time that the surgeon is called upon to decide whether or not his patient will be benefited by an immediate operation or whether by waiting twelve, twenty-four hours, or longer, he will be able to operate under more favorable circumstances. That the aphorism of Ochsner that patients came to the surgeon too late for an early operation, and too early for a late operation, is quite as true today as formerly, and upon this hinges the question of judgment on the surgeon's part as to the proper time to operate. Obviously, the patient, already toxic from the peritoneal infection which is not spreading, but showing a tendency to wall off, is better treated by expectant methods, especially if the exhaustion and worry of a long trip into the hospital has been added. Many cases, in fact the vast majority of advanced peritonitis cases, are brought into the hospitals from the surrounding country villages where a surgeon is inaccessible, or for other reasons delay has supervened, and necessarily the added exhaustion of an uncomfortable ride increases the already serious condition. Such cases, far advanced, where the tendency of the infection is not to spread, we believe are best waited on. If, however, the case is an early one; that is, the peritoneal contamination is under 48 hours old, it has been our rule to operate immediately. Hard and fast rules are impossible where combating such a condition, and there is a certain intuition which obtains in these cases as to when it is best and right to operate: The patient's expiration; the tone and rate of the pulse; feel of the abdomen as imparted to the examining finger, "whether it is stiff, board-like, and scaphoid, or whether there is present distended meteorism," all tend to influence one's judgment as to the time of operation. In beginning peritonitis in the abdomen instead of being, as it generally is, hard and scaphoid, if found to be tense and distended, the condition is more grave and consequently the prognosis is less favorable. Hence, the question when to wait is a very vital one in the treatment of this condition, and the mortality is very relative to the nicety of judgment in ascertaining just when operative interference is more advantageous.

In this series of cases we have used the expectant cases on but nine patients, all having their peritonitis from a ruptured appendix, and the routine measures were as follows: A sitting posture, nothing by mouth, ice bags to abdomen, normal salt proctoclysis. By sitting them up and draining the contamination into the pelvis, whence on account of the lymph supply it is not

disseminated, a localized abscess is formed and the general peritoneal cavity shut off. The normal salt allays thirst and at the same time acts as a diluent to toxins. Occasionally a proctoclysis of 10 per cent. solution of dextrose has been substituted for the normal salt, and while not so much of the solution will be absorbed, its nutritive qualities are of advantage. For the pain and to quiet the peristalsis, small doses of morphia, one-sixteenth to one-eighth of a grain, are given as frequently as necessary, and in highly sensitive people with a tendency to be anxious and apprehensive about their condition its value is unquestionable.

Second stage. In operating upon this series of cases where the diagnosis of peritonitis due to appendicitis was made positively, the McBurney incision was used in all males except two, and in these the right rectus incision was employed, owing to symptoms of obstruction being present also. In 67 cases the McBurney incision was employed; in 24 the right rectus route was chosen; and in nine the abdomen was opened in the mid line. For anesthetics, ether and a combination of ether and nitrous oxide have been employed invariably. In this clinic chloroform is never used, it being considered too dangerous to have a place in a surgical clinic, and local anesthesia also has not been employed. The appendix in the 75 cases operated upon in this series has been removed each time, no matter what its location. While this is not advocated as an infallible rule, yet we believe that the cases in which it cannot be gotten at safely are so comparatively small as to be insignificant. Where the etiological factor has arisen from infected tubes in women a complete hysterectomy has been done, believing the uterus to be useless under the existing conditions and better out, and also feeling that the added shock of removing it is negligible. Having removed the cause, so to speak, the remaining pus is mopped out with gauze and drainage established. The question of the kind of drainage is one of personal choice, and operators differ widely in this respect. We have invariably used the rubber tube about three-eighths of an inch in diameter and two cigarette drains of iodoform gauze wrapped in rubber tissue. The drains are put in the bottom of the pelvis, which is *always* considered the bottom of the abscess cavity, and put in before any sutures have been placed in the abdominal wall. If necessary, a finger of an assistant in the rectum is used as a girdle. We believe tubes to be the best method of drainage, *because they drain*, and have employed them with gratifying results in all peritonitis cases.

In operating upon these cases speed has not been considered so important a factor as gentleness in handling the tissues and intestines, and indeed we have noticed repeatedly that patients come off the operating table having been subjected to an hour of anesthesia, but no traction or trauma to the intestines, in a less shocked condition than one whose abdomen has been hurriedly opened, the cause of peritonitis quickly and none too gently removed, and the patient gotten back to bed in record time.

Post-operative stage: In post-operative treatment of peritonitis we have been inclined to discard in a large measure therapeutic agents and depend largely upon mechanical means, viz: the stomach tube and enema tube. Immediately following operation the patient is put in the sitting posture, the bed being inclined at an angle of about 45 degrees; all foods and medicines by mouth discontinued in an effort to keep the stomach entirely empty, and a proctoclysis of either normal salt or 10 per cent. sugar solution instituted. The substitution of sugar solution for salt is of special advantage in far-advanced cases where the patient is starved out as well as toxic, and the nutritive value of the sugar is of service, it acting as a diluent to the toxines at the same time. The average peritonitis patient will absorb about two to four thousand c. c. of either solution in 24 hours, but there is a point reached at which the bowel rebels and no further absorption takes place, but the solution accumulates in the colon, which becomes loaded with the poisonous products of the peritonitis, and resorption begins. When the bowel refuses to take up more solution, the residue should be syphoned off and the protcoclysis discontinued for several hours, and then restarted; the process of syphoning off the bowel repeated, and especially in the first 72 hours of the disease we consider it one of the most important steps in the post-operative treatment. With the patient in a prone position, a stiff rectal tube is inserted, and as much contents of the bowel as possible syphoned off. Following this, the rectum is distended with hot soapsuds, and in this condition it is often possible to insert the tube through the valves of the rectum into the descending colon. The bowel is then washed out with from one to two gallons of hot soapsuds. The syphoning is accompanied by gentle massage over the entire abdomen, beginning over the sigmoid and following the course of the colon around to the right iliac fossa, thus stripping the bowel of its contents from its last point first, just as one would twist the contents of a stuffed sausage. In this manner, which is practically without pain to the patient, the poisonous products of the intestinal tract are gotten rid of, reabsorption prevented, and peristalsis, which has been paralyzed, started up again. Instead of a stiff, rigid, meteoric abdomen, the patient is left in a comfortable state, with a softened, pliable, undistended belly. If nausea and vomiting persist in spite of nothing by mouth, the stomach is repeatedly and persistently washed out. For the first two days the bowel is syphoned off B. D., as a routine, and as much oftener as is necessary to prevent reabsorption or allay distention. At the end of 24 hours one of the cigarette drains is removed, and at the end of 48 hours the other. The tube is changed to one of smaller caliber at the end of 72 hours, and on the following day one of smaller lumen is again substituted and its length shortened. At the end of 72 hours drainage is very slight, and in the vast majority of cases unless a small pocket of pus is found at the bottom of the drain tract, the patient should show no temperature and be well along to recovery. By the end of the

seventh day all the drainage is out and the drain tract generally about an inch and a half in depth. This slight opening is kept packed with iodoform gauze and allowed to granulate up. The wounds heal rapidly and almost resemble a clean incision when the patient is discharged from the hospital. Thirteen days is the shortest period of recovery of any case of diffuse peritonitis in this series. Morphia is practically the only drug employed in these cases, and it has been given in small doses and only when patients complained of great pain or were very restless on following operation. All stimulants except the morphia have been rigidly withheld. Indeed, we believe that they are not only contraindicated, but harmful if administered in such cases and in large doses.

Feeding: Feeding has been begun at the end of 48 hours with small quantities of plain egg water and small quantities of broth, provided the nausea following operation has subsided and the patient retains the food.

In this series of cases the two complications most to be feared; namely, fecal fistula and post-operative ileus, have not occurred. Two post-operative hernias resulted, both in elderly women. In one case the perotinitis was from a ruptured appendix, and the hernia occurred in the McBurney incision which was left wide open at the time of operation. In the other case hernia occurred in a mid-line incision, which was used also for a general peritonitis from a ruptured appendix. Both conditions were subsequently corrected, with no ill results to either patient.

The suture materials in this series of cases have been plain catgut for the peritoneum, chromicized catgut for the fascias, and subcutaneous silver wire. Since instituting the use of catgut in drain cases, wound infections have disappeared, the wounds healing up so quickly and the irritation due to foreign bodies, such as silk, being done away with.

To summarize briefly, we believe first the selection of the proper time for operation is of the most material advantage to the patient.

Second: Ether and nitrous oxide and ether are the anesthetics of choice, and if properly administered are in no way harmful to a patient already decidedly toxic.

Third: Thoroughness should never be sacrificed for speed, for gentleness in handling tissues should be observed in all cases.

Fourth: Properly placed drainage and position of patient after operation are very vital factors towards success in combating with peritonitis.

Fifth: Constant and persistent syphoning of the bowel, ridding the patient of the poisonous products of his peritonitis and relieving the uncomfortable meteorism and getting the normal peristalsis rebegun tends both to the comfort and recovery of the patient.

Sixth: Therapeutic agents are of little or no value in combating this condition.

DIETL'S APHORISMS ON PHLEBOTOMY.*

By Norman B. Gwyn, M.D.,
Philadelphia.

While searching for some references upon the subject of bleeding in pneumonia, I was confronted with the familiar name of Dietl, Joseph Dietl of Vienna and Cracow, and found under it a long monograph, "Der Aderlass in Lungen-entzündung." The 102 clinical aphorisms with which this monograph terminates form the subject-matter of my paper.

"Der Aderlass" seemed to have helped to make Dietl's reputation long before his accurate description of floating kidneys and the crises which bear his name. It is generally referred to as one of his chief contributions to the medical sciences, and one naturally wondered after glancing at his tables of 380 cases if there might not be in 102 conclusions much that, at least, was interesting.

And interesting indeed I found them. Hippocratic at times in their truth and brevity. "Schlecht ist es wenn der Puls schon nach der ersten Venesection frei wird," might well have come from the *great collection* of aphorisms, while "Es gibt Pneumonien ohne Husten," "Es gibt keine chronische Pneumonien," "Die besten Pneumonien sind die bei denen nur wenig expectorirt wird," must satisfy the most vacillating student.

My interest waned somewhat on observing the date, 1848—twenty years after Louis; but the Cracow societies were still debating "bleeding in pneumonia." Louis was still showing an affection for early bleeding and tartar emetic, and I felt, moreover, that the observations of one, who at that early date, and long before it, would courageously carry through 189 cases of pneumonia, on dietetic measures alone, must not only be of interest, but of real value if honestly set forth.

As far as one can judge, Dietl advances his arguments against blood-letting quite as if Louis' great protest had never been made. Dietl's methods are nevertheless Louis' methods—careful clinical observations ending in accurate statistical details. One senses an imitation, but hopes that the omission of any reference to Louis' work is accidental. Andral receives recognition in a reproof for his bloodiness; Laennec is completely ignored.

Dietl, as he says in his "Vorwort," belonged to those strong "Antiphlogistiker," who still saw in the then bloody treatment of pneumonia their greatest triumph. Seventeen years previously some taint of heresy had crept into his mind, for in the years 1831-2-3 he had tried treating severe cases of pneumonia homeopathically—"Aber es fehlte mir jedoch der Muth den natürlichen Verlauf der Krankheit ruhig abzuwarten. Mit der zunehmenden Athemlosigkeit und Angst des Kranken stieg auch die meinige so hoch, dass ich in mitten der präsumptiven Arzneiwirkung

*Read before the Book and Journal Club of the Medico-Chirurgical Faculty of Maryland, November 17, 1914.

reuig nach der Lanzette griff, und, da diese in den meisten Fallen Erleichterung brachte, wieder zur alten Fahne schwur, der ich nun fester anhing als je."

Clinging "fester als je" he must have remained for nearly ten years, for his "Bezirks-Krankenhaus" appointment in 1841 found him "bleeding industriously."

Bleeding, however, had a rival. For many years Tartarus stibiatus had "proved itself" with the profession, and it was being found that in some cases one did not need to bleed if large doses of tartar emetic were given. The majority of teachers, even Louis, simply went from bleeding to antimony in twenty years. Dietl stepped from bleeding to large doses of tartar emetic with vomiting, from large doses with vomiting to small doses without vomiting, from small doses to no doses (an expectant treatment of pneumonia) at a revolutionary rate. Then followed three years' observation of pneumonia treated without bleeding, and at the end of this period was put forth the "Aderlassung in Pneumonie," a protest larger at least, and more elaborate, than the great protest of Louis.

It is not my intention to review critically Dietl's monograph; it might be entertaining, for the indications of his later therapeutic Nihilism are already apparent, but to most of us prolixity and a dogmatic positiveness would seem its chief characteristics, the carping reference to Andral is the only mention of any of the great teachers who had gone before him.

Almost every phase of pneumonia and the influence of bleeding upon it is taken up in the monograph; the aphorisms, of course, merely represent the crystallized result. Many have the stamp of originality, their brevity and conciseness is attractive to a degree. They can possibly be presented more briefly and agreeably by using some reconstruction; Dietl's scheme in general can be easily followed—certain conditions of pneumonia are taken up, the application of bleeding considered, the probable or actual results detailed, and the dire effects of bleeding stated.

Not every aphorism pleases. I will try to put before you the more interesting and the most original:

APHORISMS ON THE PRODOMES.

"The prodomes of pneumonia last longer in the young and strong, and those affected for the first time, are shorter in the aged, weak and those undergoing recurring attacks."

(2) "Venesection has the power to shorten the prodomal stages."

Dietl at no time denies that bleeding gives temporary relief.

APHORISMS ON THE DYSPNOEA SEEN IN THE EARLY STAGES OF PNEUMONIA.

"The pneumonia patient breathes easier after completed hepatization than before."

"The dyspnoea is not due to the filling of the lung cells with the plastic exudate."

"Complete hepatization may limit the respiratory movements without bringing about respiratory distress."

"The gaseous interchange in the lung cells is the ultimate inciter of the regulated activity of the nerve centers and the respiratory movements dependent thereupon."

"On account of the enormous accumulation of fibrin as a protein-oxide a large amount of oxygen is withdrawn from the blood, and since there is reduction of the blood cells (the oxygen carriers) this, the oxygen, is never replaced in the same proportion."

(12) "In pneumonia less acid is taken out of the atmospheric air than is necessary for oxidation of the venous blood and the vitalizing of the nerve centers."

(13) "The dyspnoea then must clearly be greatest during the period of the pouring out of the fibrin into the lung cells. Since then, the greatest call for, and the greatest deficiency of oxygen is taking place."

(15) "The pneumonic's dyspnoea is preferably induced by altered chemical proportions of the blood."

(17-18) "Venesection should relieve dyspnoea by helping onward a continuous blood stream, more blood being driven through the capillaries in a given time, and (18) no other means of treatment suffices so to relieve dyspnoea, but (16) venesection brings about in the blood the same alterations as the pneumonic process (reduction of red blood cells and increase of fibrin), so that generally, it must from *chemical* reasons rather increase than diminish dyspnoea."

ON THE HEART.

(24-23) "The exudation process, the underlying disease itself, is the most probable cause of the increased pulse rate, rather than mechanical obstruction or the reduction of the red cells."

(25) "The pulse rate drops after the venesection," but (26) "the influence of venesection is usually only transitory," and (28) "can only occur if the individual is sufficiently full-blooded."

(31) "In the unbled pneumonia there is seldom seen the same amount of cardiac disturbance as in the bled."

(32) "The tumultuous heart actions are in part consequences of the venesection."

ON THE PULSE.

Venesection followed very largely the pulse character. The quiet repressed pulse was considered favorable, the large dicrotic unfavorable, often seen in severe pneumonias and often bled for. To Dietl's mind large pulses more regularly followed bleeding, were a sure sign of increased serosity of the blood, and asthenia; it was bad if they followed the first bleeding, and, further, he asserts that the return to a small normal pulse from a large dicrotic one was never so quick in the venesected cases as in those treated by dietetic measures alone.

"The pulse of the pneumonias is dicrotic, but not completely so as in typhus."

"The repressed pulse of the older pathologists is the normal and favorable, the large dicrotic, the abnormal and unfavorable of the various pulses of the pneumonias."

"After single or repeated bleedings the pulse becomes large and dicrotic, it becomes 'free,' as one is accustomed to say. This 'becoming free' of the pulse is a sure sign of increased serosity of the blood and asthenia."

"It is bad if the pulse becomes free after the first bleeding."

"In pneumonia treated by venesection, the large dicrotic pulse never returns so quickly to the normal as it does in those treated by dietetic measures alone."

ON THE JAUNDICE SEEN IN PNEUMONIA.

Bilious pneumonias, our pneumonias with jaundice, were, by Dietl, seen to occur in direct proportion to the extent of the bleeding. Jaundice occurred but seldom in, and quickly disappeared from the cases not molested by the lancet. While, on the contrary, it could be seen to deepen after each opening of the vein, and, in many instances, was directly produced thereby. To instance this:

"The yellow color of the skin begins to decrease immediately after the completion of the exudate, and disappears within the shortest time."

"The yellow color of the skin occurs less often in the unbled cases."

"The jaundice increases after each bleeding."

"The jaundice is in many cases directly brought about by the bleeding."

It was interesting to note in connection with the question of jaundice in pneumonias that the pathologists of Dietl's time had recognized that obstruction of the large ducts, and gross liver changes were not usually demonstratable in the fatal cases; to fasten the blame for the jaundice upon the bleeding would be Dietl's natural inclination in this case, and in the substance of the monograph we find that "Venesection promotes excretion of and coagulation of the fibrin to a high degree, and from this comes an abnormal collection of pigment in the blood."

ON THE SPUTUM.

That group of aphorisms which concern the sputum and the effect of bleeding upon its character makes one feel certain that Dietl must have been quite unacquainted with both Laennec and Louis, or that he willingly is ignoring both. He still busies himself with the venesection's power to produce the "Sputa cocta" in the face of Laennec's clear description of the pneumonia expectoration, and his assault on bleeding is delivered at Andral, quite over Louis' shoulder, as it were: "Andral und andere Beobachtern die die Lanzette stets bei der Hand haben." Two of the aphorisms stand out:

"The best pneumonias are those in which there is but little expectoration."

"The sputa cocta are not a necessary product, nor are they to be considered as a critical evacuation."

To these he adds the following:

"It is a very favorable sign, and one pointing to a quick resolution, if the expectoration ceases after completion of the exudate."

"In the treatment of pneumonia by venesection the sputa undergo several alterations among which is the transformation of the clear, tenacious expectorations into the so-called 'sputa cocta.'"

"Venesection favors the breaking down of the pneumonic exudate into pus or pus-like cells, and, indeed, 'sputa cocta' are often the product of venesection."

As we saw in aphorism 2, Dietl was fair enough to give credit to bleeding for certain minor qualities, one other of these was its apparent power to relieve cough in the early stages.

"Incontestable experience teaches that a single venesection will often lessen a cough or even completely subdue it."

"The short, dry cough of pneumonia is due to the hyperesthesia of the lungs."

"The actual cause of the cough is a bronchitis."

"Venesection lessens the cough by subduing the pulmonary hyperesthesia and by diminishing the bronchial secretion; a similar mode of action is at work in the relieving of the dyspnea."

Nihilism breaks forth in his declaration *"The expectant treatment has no remedy for the pneumonic cough."*

Few of us realize how drastic the treatment of disease could be before the various protestants had effected their reformation. The convalescence of any serious ailment must have been much prolonged, the critical resurrection of a pneumonia patient must have been often actually interfered with. Laennec realized this to a degree; Louis' arguments are always along rather different lines, and *he* could still see the marked improvement after the vomiting caused by the tartar emetic. Dietl would seem to strike here his highest note. Some of his aphorisms on this stage of pneumonia are:

"After the completed exudation in the unmolested pneumonia, the physiognomy expresses the highest degree of well being."

"In the cases treated by bleeding this favorable change of the physiognomy does not show in so striking a manner, because the weakness induced by the bleeding does not leave the patient free to enjoy his return to well-being."

"In the expectant treatment the appetite returns immediately after the completed exudation; there is seldom craving for heated foods."

"In the venesected cases the appetite returns but slowly, there is often a craving for hot food."

"In the cases treated by venesection there is much greater wasting than in those treated by dietetic measures."

"In the expectantly treated pneumonias the weakness vanishes with the completed exudation and the patient rapidly recovers;

in the venesected cases the patient may feel better, but he has yet to go through a long siege of weakness."

"The length of convalescence is much shorter in the expectant than in the venesecting treatment."

Dietl realized that bleeding had but little effect upon the lesion. He says in this connection:

"Clinical and physiological observations speak for the fact that bleeding has no power to limit the pneumonic exudate."

"Venesection even favors the extension of the hepatization."

"Many in- and extensive pneumonias occur and flourish under the lancet."

A few more generalized dicta remain; they lead us to a forceful climax.

"A pneumonia left to itself is very seldom fatal."

"Pneumonia treated by venesection is often fatal in itself."

"The expectant treatment of pneumonia shows a much more favorable mortality record."

"Venesection has a certain and none too innocent a part in the great mortality of pneumonia."

"Venesection kills by increasing the blood disturbance."

"Bleeding is not necessary to the re-establishing of health, and, therefore, is not indicated."

"Bleeding in many cases *works real harm*," and though "no measure may at times give such striking and quick relief," yet "the application of bleeding in pneumonia is to be limited to the utmost, or, what is safer, is to be thrown completely aside."

REVIEW OF DERMATOLOGY AND SYPHILIS.

By Lloyd W. Ketron, M.D.

REMOVAL OF SMALL-POX SCARS.

UNNA (*Berliner Klin. Wochen.* No. 40, 1914), after reviewing the various methods of removing scars by polishing stones and powders, electrolysis, scarification and peeling pastes, comes to the conclusion that the method of choice is the treatment with carbon-dioxide snow. In small doses it makes the tissues more liable to resorption and causes a raising up of the atrophic and sunken areas.

As long applications are to be avoided, and each person reacts differently to the snow, one must first test the skin to ascertain how much can be given without producing large blisters. In most cases 5 to 10 seconds is enough.

If the scars are very thick it may take 20 seconds. The size of the application should correspond exactly to that of the depression or elevation, as the case may be, although, in some instances, it is

best to treat large areas without reference to the individual scars, and later, if necessary, treat the remaining lesions separately. One does not wish to cause a necrosis of the cutis, but to better the circulation and raise the depressed areas, so that oft-repeated small doses should be used. Summing up, and using the best of the various methods, one can remove the coarsest disfigurements by the scarifications of Vidal; then, through electrolysis, the most apparent raised areas can be disposed of. After this comes the principal treatment with the snow, which may be followed by salicylic-acid plasters or better by the thiosiamin cataphoresis, which hastens resorption. For the last uneven areas the polishing methods are best.

LICHEN URTICATUS OF URTICARIA PAPULOSA.

This disease, although rare in this country, is of general interest because of its probable relations to some constitutional derangement. It is discussed by Barker in the December issue, 1914, of *The Practitioner*.

Following Darier, the author defines the condition as a prurigo characterized by (1) The appearance of papules of a distinct histological structure which often arise on an urticarial base. (2) The sudden outbreak of eruptive elements in crops on any part of the body. (3) The usual absence of lichenification or of any complicating eczematous condition. (4) A limited duration of some weeks or months, but a great tendency to recurrent attacks. (5) A prognosis which is on the whole favorable.

Barker believes that the condition belongs to the group described by Czerny and others as "die exudativ-lymphatische Diathese," and that there is evidence that it may depend on abnormalities of the ductless glands. The association of the disease with an unhealthy condition of the lymph structures, adrenals and with the alimentary symptoms characteristic of the exudative diathesis is too frequent to be coincidental.

The exciting causes are intestinal upsets, teething, external irritants due to vermin, coarse underclothing and decomposing sweat. The part psychical disturbances play is not clear, but it seems certain that insomnia and irritability produced by the itching prolong the attacks.

The treatment which is often unsatisfactory comes under three heads: (1) Alimentary. Carious teeth should be attended to and regularity of meals, with nothing in between, should be insisted on. Calomel should at first be given, followed by a morning purge, and afterwards the bowels kept regular. Intestinal antiseptics, such as ichthyol (2 drops t. i. d. for a young child), are often of value. (2) Local. Cool, non-irritating clothing should be worn next to the skin. A 10 per cent. menthol in zinc oxide ointment has given the best results for a local application. In the free periods, if the skin is dry and harsh, the Ung. glycerini plumbi subacetatis is of service in preventing recurrences. (3) Nervous system. Any source of reflex irritation should be removed. The tonsils, adre-

nals, foreskin, etc., should be investigated. When a sleeping mixture is indicated the bromides and belladona give good results.

MINERAL WATER METHODS IN THE TREATMENT OF SYPHILIS.

The success of one's treatment of syphilis depends a great deal upon the general condition of the patient. This is shown in the cases of malignant lues, where the inability of the patient to form antibodies makes the administration of antiluetic drugs of little value until his general condition is bettered.

Of the adjuvant measures in the treatment of the disease, the mineral waters occupy a very prominent place. These methods of treatment are discussed by Dr. Dardel of Aix-les-Baines. (*Urologic and Cut. Review*, October, 1914, Technical Supplement.) There are three kinds of spas adapted especially to the treatment of syphilis, namely, those containing chlorinated iodin waters, those with arsenical waters and those with sulphurous waters. These all exert complex actions on the various metabolic functions of the body, for which the reader must be referred to the original article. The action of the sulphurous waters are of especial interest because, in addition to their general action, they exert a definite action on the specific medication by facilitating the elimination and absorption of the mercury, thereby permitting a more intensive treatment.

This action of the sulphurous waters is explained by the writer as follows: "Metallic mercury and the various salts used in medicine are not absorbed in the metallic state, but in the form of the bichloride or such compounds as the chloro-bromin, chloroidin and chloro-mercury. * * * Bichloride of mercury forms, with albuminoids, a white precipitate insoluble in water. On the other hand, an excess of albumin or a solution of an alkalin chlorid can redissolve this precipitate of mercury albuminate and place it anew in the circulation. The sulphurous waters reinforce the compounds capable of redissolving the albuminate or mercury a great deal better than the sodium chlorid, which is the principal substance in the organism to bring about the circulation of the mercury. * * * The sulfurous waters may contain not only hydrogen sulfid and sulfates, but also alterable products of these substances, and the alterations are more rapid the more the water is charged with silicates. The sulfur of the hydrogen sulfid and the sulfates is set free by the action of the carbon dioxide and the oxygen; it then becomes oxidized itself little by little, giving rise to hyposulfuric acid, sulfuric acid or the soluble salts of these acids, the soluble sulfate representing the last stage of oxidation. In 1914 Desmoulieres showed experimentally this action of the sulfates on mercurial compounds. Adding 5 cc. of serum to 2 cc. of a solution of bichloride of mercury, he obtained a white precipitate. If now 2 cc. of the monosulfate of sodium (a 1 per cent. sol.) are added, the precipitate is at once dissolved.

"The hydrogen sulfid plays an analagous role to that of the monosulfate. The passage of small quantities of the gas allows the

redissolution of the precipitate of the albuminate of mercury. The hyposulfite and the sulfite possess the same power of solubility, but the sodium sulfate, on the other hand, has no such action. Therefore, the action of the sulfurous water is greater the more the products in the water are unoxidized."

Although the thermal cures are of advantage in every case of syphilis, the author believes that they are especially indicated in the following: (a) When the administration of mercury does not have the desired therapeutic effect. (b) When the necessary dose of the mercurial preparation is not tolerated. (c) If the Wassermann remains positive in spite of energetic treatment or if after treatment it becomes rapidly positive again. (d) If the syphilis has a malignant character, or if the nervous system appears to be menaced. (e) If the patient's general condition is bad, and in cases of hereditary syphilis.

As to the time of giving the thermal cure, i. e., during or after the mercury cure, the author believes that the results are far superior if the two are given together. By this method the solubility of the mercury is enhanced, and instead of accumulating in the tissues it is carried to all parts of the body in a soluble form and a culminative action is avoided.

The intramuscular injection of the soluble salts is the method of choice in the administration of the mercury because by this means one knows the exact dosage and the effect is immediate. The benzoate and the bibromid of mercury are preferred.

TREATMENT OF BROMIDROSIS WITH GLYCERINE.

Because of the effect of glycerine in preventing the formation of indol in cultures of indol producing bacteria, Penians (*Lancet*, December, 1914) conceived the idea of using glycerine in bromidrosis. The fermentation of glycerine also leads to the production of an acid medium, and this would tend to inhibit the growth of certain putrefactive bacteria. The results of the treatment were excellent, but a relapse always occurred when it was discontinued. As this, however, is true in many cases, no matter what treatment is used, the method may prove to be of service.

GERMICIDAL ACTIVITY OF CHRYSAROBIN.

Some rather interesting observations have been made by Schamberg and his associates (*Jour. Cut. Dis.*, January, 1915) on the comparative germicidal activity of chrysarobin and calomel. It was found that the former has practically no effect in inhibiting the growth of the staphylococcus albus in the test tube, while the latter absolutely stops the growth of this organism in quantities of .0005-.001 gram in 0.1 cc. of a 24-hour broth culture. The especial interest attached to these results is due to the fact that chrysarobin is the most powerful remedy we have against psoriasis, while calomel has practically no beneficial results in the treatment of this disease.

Book Reviews.

A Textbook of the Practice of Medicine. For Students and Practitioners. By Hobart Amory Hare, B.Sc., M.D., Professor of Therapeutics, Materia Medica and Diagnosis in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; One Time Clinical Professor of Diseases of Children in the University of Pennsylvania; Author of a Textbook of Practical Therapeutics and Diagnosis in the Office and at the Bedside. Third Edition. Revised and Enlarged. Illustrated with 142 Engravings and 16 Plates in Colors and Monochrome. 1915. Philadelphia and New York: Lea & Febiger. Cloth. $6 net.

No one needs an introduction to the superior quality of the literary productions of Dr. Hobart A. Hare. His name attached to the title page is a sufficient guaranty of the character of the contents. As in his other writings, so here the style is easy, the language concise and to the point, thus enabling him to cover the most ground with the least amount of space. A noticeable feature of the book is the practical nature of the pages. Everywhere one is impressed with this utility feature. And why shouldn't such be the case, when one takes into consideration the long years spent by the author at that storehouse of medical knowledge, the patient's bedside. Each page impresses one with the profound acquaintance the author has of clinical medicine. Abundant and unstintedly has he transcribed this information to the pages of Hare's Practice of Medicine. Readers will find the volume well balanced as regards the amount of attention devoted to etiology, diagnosis, differential diagnosis, prognosis and treatment. They will also find incorporated in the text the latest scientific methods employed in diagnosis. The treatment is absolutely the latest, and absolutely reliable. Indeed, it is impossible to pick out any one aspect of the book in which it is weak. Some books are good on diagnosis, others on treatment, and so on, but here the student and physician gets a one-volume book in which every aspect of the subject under discussion is handled strongly and thoroughly, and withal sufficiently full to be intelligible. It gives us great pleasure to recommend the present edition of Hare's Practice of Medicine to the patrons of the Maryland Medical Journal.

Chemistry and Toxicology for Nurses. By Philip Asher, Ph.G., M.D., Dean and Professor of Chemistry at the New Orleans College of Pharmacy, New Orleans. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1914. Cloth, $1.25 net.

This book answers its purpose admirably, being a guide to beginners in chemistry and toxicology. The authors have with a keen perception of balance included just a sufficiency for nurses' purposes. The book is written in as simple diction as possible, so that the class to which it is directed can quickly obtain an insight into the elements of chemistry and toxicology. It is an excellent book and well serves its purpose.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, APRIL, 1915

THE MORTALITY PROBLEM.

ACCORDING to United States Government statistics, the annual death rate from the degenerative diseases is ever on the upward trend. The increase has become so alarming that this question to many far outweighs the prevention of tuberculosis, hookworm, and even cancer; burning problems as they are, they are minor in comparison with the degenerative diseases of the urinary and circulatory apparatus. All know that statistics can be twisted to subserve any end, that statistics cannot always be relied upon. But when we learn that there is an increase of 40 per cent. between the death rate of 1890 and 1910 from these diseases, surely it is time to give the question due consideration. Undoubtedly Americans have been living at too rapid a pace, else such would not be the case. Therefore it is time the public be educated in the early recognition of failing kidney or circulatory function. Arterio-sclerosis, chronic insterstitial nephritis, myocarditis and fatty heart are to a large extent preventable. They are largely due to abuse of the body by overeating and drinking, worry, lack of exercise, unnecessary infections, such as syphilis, typhoid, etc. There are now approximately 410,000 deaths in the United States annually from organic diseases from the kidney and circulatory systems, about 60,000 of which occur below the age of 40, 350,000 beyond. It is safe to say that at least 75 per cent. of these deaths could be postponed if the public were taught how to guard against these afflictions and how to live after their contraction. Such campaigns as have been waged against tuberculosis, etc., have exerted a powerful influence in lessening their prevalency; a similar campaign would likewise work wonders here. If the people could be made to understand that Bright's disease does not necessarily mean death, that at its

incipiency much can be done to retard its progress, then a big step forward in the prolongation of life would result. Such being the case, there is no excuse to longer ignore the waste of vitality and life that is going on in this great body of citizens. The Life Extension Institute has recently issued a pamphlet directing attention to this unnecessary economic loss, hoping thereby to interest the public and the profession in this aspect of medicine. To be sure, the pamphlet deals with the sinister side of the question, but most physicians will be thoroughly in accord with the statement "This adverse mortality trend from organic diseases can no longer be disposed of by the easy process of denying the accuracy of the statistics or of their analysis. Nor can it be solved by charactetrizing those who are calling attention to this condition as pessimists, for optimism of the most cheerful sort is the foundation upon which the movement to check this life-waste is built. If it were hopeless we would not engage in the effort. But by the application of knowledge which science and experience have given us, and because thousands of people have already learned how to ward off or postpone these afflictions leads us confidently to believe this excessive waste of mature and valuable lives can and will be checked." Those in charge of the movement have implicit faith in the ability of the American people to grapple with the problem when thoroughly aroused to its importance. So far the public has been too much engrossed in the gaining of wealth to realize its seriousness. Some, however, have noticed the trend of events and are alive to the necessity of focusing the public's eye upon what can be done in the prevention of organic diseases and prolongation of life after their onset. Now that the wave has started, it will gradually gather more and more force, so that in the not distant future the public will be as familiar with the measures employed in the prevention of organic diseases of the heart and kidney, as with those against the spread of tuberculosis. The remedy briefly stated is the diligent practice of personal hygiene. This implies the observance of moderation in eating and drinking, avoidance of overindulgence of any sort, total abstainance from strong drink, narcotics and tobacco, plenty of good healthy outdoor exercise, and a life of purity. A necessary adjunct in the prolongation of life is periodical physical examination, as thereby diseases of these systems are detected in their incipiency. We hope our readers will take this lesson to heart and exert all the influence they can in spreading the gospel of right living, and thereby aid in the prolongation of life.

Medical Items.

Dr. L. F. Barker of Johns Hopkins University delivered a lecture at Hood College, Frederick, Md., recently to more than 500 persons on "Maintenance of a High Standard of Public Health." The lecture was under the auspices of the Civic Club. Dr. Barker was the guest of Dr. Thomas B. Johnson. Joseph D. Baker presided. Following his address three-minute talks were given by Dr. Ira J. McCurdy, city health officer; Dr. Joseph H. Apple, president of Hood College, and Dr. T. Freeman Dixon, president of the Federated Charities. A rising vote of thanks was tendered Dr. Barker.

A campaign to raise $50,000 for the Skin and Cancer Hospital was started recently with a "tag day," in which the Ladies' Auxiliary of the hospital and several hundred girls took an active part, assisted by the Women's Civic League. The hospital was founded as a forerunner of a campaign in this city to educate the laymen in regard to cancer and its prevention and cure. In the two years since its opening it has cared for 336 cases, the majority of them charity patients and many of them not admitted to other hospitals—except Bayview—because they were in the inoperable and incurable class.

Dr. William H. Welch of Johns Hopkins University has been appointed a member of the "China Medical Board of the Rockefeller Foundation," of which John D. Rockefeller, Jr., is the chairman.

The city health officer of Cumberland has recommended the establishment of a sanatorium on Haystack Mountain for the cure of negroes afflicted with tuberculosis.

The Board of Estimates of Baltimore has given authority to Dr. J. Hall Pleasants, Jr., Johns Hopkins Medical School, '99, president of the supervisors of city charities, to spend about $10,000 on improvements at Bayview Asylum. It is thought that the tuberculosis ward will be practically rebuilt at a cost of $5000.

The seventeenth annual meeting of the Medical and Chirurgical Faculty will be held on April 27, 28 and 29 at the Faculty Building, 1211 Cathedral street, Baltimore, Md. Dr. J. M. H. Rowland is chairman of the Committee on Scientific Work and Arrangements.

Dr. William Lee Smith, Physicians and Surgeons, '87, of Riderwood, Md., who has been ill for some time, is slowly improving.

Dr. Newell A. Christensen, in charge of the accident ward of the Mercy Hospital, has tendered his resignation.

The National Conference of Charities and Corrections will be held in Baltimore from May 12-19, inclusive.

The Public Health Conference held recently proved so successful that it has been decided to hold a series of lectures on health topics for negroes exclusively.

To study methods employed in the Johns Hopkins Hospital, Dr. R. W. Large of Port Simpson, British Columbia, spent about ten days in the city last month. He also visited hospitals in Washington, Cleveland and Toronto. For nearly 16 years Dr. Large has labored in the great frozen regions, and his patients were principally lumber jacks and salmon canners. He traveled about among the sick on sleds, and until a short time ago the nearest hospital was 500 miles from Port Simpson. Recently a hospital has been opened at Prince Rupert, about 25 miles distant. Dr. Large is assisted in his work by his wife and five nurses, and the government lends aid to the hospital.

Dr. Nathan Winslow, of 3304 Walbrook avenue, Baltimore, announces that he will limit his practice to general surgery.

Dr. Robert L. Blake, Baltimore Medical College, '05, of 857 Columbia avenue, recently delivered a lecture at the Young Men's Christian Association on the prevention of tuberculosis.

Dr. Robert P. Bay announces the removal of his offices to The Walbert, 1800 North Charles street, Baltimore, Md. His practice is limited to general surgery. Consultation by appointment.

Dr. Lewellys F. Barker has been spending some time at the Greenbrier White Sulphur Springs, West Virginia.

Dr. Alan Churchill Woods, who has been the guest of his parents, Dr. and Mrs. Hiram Woods, at their residence on Park avenue, left

recently for Boston, where he is connected with the Peter Brent Bingham Hospital.

The decennial celebration of the Phipps Tuberculosis Clinic of the Johns Hopkins Medical School was held February 24th in the amphitheater of the hospital. There were interesting discussions on various phases of tuberculosis.

The real work done in the clinic in the last 10 years is of great interest and importance to the public as well as the profession.

Since February 21, 1905, when the clinic was opened, there has been an unrelenting fight made on tuberculosis. The work has been done quietly in the little red brick building on Monument street, near Rutland avenue, but the results of that campaign have reached to many parts of the country.

In that time there have been approximately 10,000 persons treated.

Hundreds of students have been taught how to combat the plague. Many of these students, now doctors, are preaching this doctrine throughout the country.

Drs. Louis V. Hamman, C. R. Austrian, Samuel Wolman and others have spent years in investigation and research work.

Eleven years ago, when Henry Phipps, the Pittsburgh philanthropist, made a donation to Sir William Osler, then professor of medicine at Johns Hopkins, he said he wanted the money used where it could do the most good. Sir William suggested the founding of the tuberculosis clinic.

BIRTHS.

To Harry D. McCarthy, M.D., University of Maryland Medical School, '05, and Mrs. McCarthy of 37 West Preston street, Baltimore, February 18, 1915, a son—Horation Ball.

To James Herbert Bates, M.D., University of Maryland Medical School, '07, and Mrs. Bates of Millington, Md., February 28, 1915, a daughter—Margaret.

Recently to J. Dawson Reeder, M.D., University of Maryland Medical School, '01, and Mrs. Reeder of 639 Fulton avenue, Baltimore—a daughter.

MARRIAGES.

Frank M. Eccles, M.D., Physicians and Surgeons, '81, of Oxford, Md., to Miss Ethel Ray Neal of Cambridge, Md., at Baltimore, March 10, 1915. Dr. and Mrs. Eccles will reside in Oxford.

DEATHS.

D. Virginia Hilken, R.N., Mercy Hospital, Baltimore, class of 1913, died after a lingering illness at the Mercy Hospital, January 21, 1915. Her alumnae association passed resolutions upon her death, a copy of which was framed and hung with her picture in the Clubhouse.

Walter Linton Brown, M.D., Physicians and Surgeons, '13, died of heart trouble at Mercy Hospital, February 23, 1915, aged 41 years. Dr. Brown served as an intern in the surgical department of Mercy Hospital from June, 1913, to July, 1914. He was then made superintendent of the hospital in Richwood, W. Va., and remained in charge of that institution until he was taken ill in January.

Thomas E. R. Miller, M.D., of Lewistown, Md., died suddenly at his home, Valley View, February 28, 1915. Dr. Miller dropped dead in his office while prescribing for a patient.

Edward Francis Ford, M.D., Maryland Medical College, Baltimore, '91, a physician and druggist of Chester, Pa., died in the Chester Hospital February 4, 1915, from cerebral hemorrhage, aged 39 years.

Joseph Walter Sim, M.D., University of Maryland Medical School, '92, health officer of Glenwood, Md., died at his home January 8, 1915, aged 57 years.

James H. Glass, M.D., College of Physicians and Surgeons, '84, died at his home in Paso Robles, Cal., January 8, 1915, aged 57 years.

Abram Trego Shertzer, M. D., University of Maryland Medical School, '60, fleet surgeon of the United States Volunteers during the Civil War and staff surgeon in the German service during the Franco-Prussian War, a practitioners of Baltimore for nearly fifty years, local surgeon to the Pennsylvania System and the Baltimore City Railroad, died at his home in Baltimore January 22, 1915, from heart disease, aged 70 years.

Henry W. McLaughlin, M.D., College of Physicians and Surgeons, '85, died at his home in Marietta, Ohio, January 20, 1915, from locomotor ataxia, aged 54 years.

Editorial Comment.

A UNIFORM FEDERAL LICENSING ACT.

The Medical Times.

The active interest aroused in the profession and among contemporary journals by a recent symposium conducted by *The Medical Times* upon the subject of a uniform federal licensing act moves us to depart for a brief space from the realms of medicine and to venture a slight incursion into the province of our sister profession of law.

We have been advised that no federal licensing act is possible without an amendment to the United States Constitution.

This opinion has been challenged in some quarters—lay, medical and legal.

In support of the opinion which has been expressed to us and which carries much weight with us, we desire to quote certain extracts from decisions of the Supreme Court of the United States, which, we are informed, are controlling upon the question.

The first proposition that we advance is that the licensing of physicians and the provision of qualifications thereof is a matter within the police power of the separate sovereign States of the Union.

Mr. Justice Field, in the case of Dent v. West Virginia, 129 U. S. 122, said:

"The power of the State to provide for the general welfare of its people authorizes it to prescribe all such regulations as, in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity as well as of deception and fraud. As one means to this end it has been the practice of different States, from time immemorial, to exact in many pursuits a certain degree of skill and learning upon which the community may confidently rely, their possession being generally ascertained, upon an examination of parties by competent persons, or inferred from a certificate to them in the form of a diploma or license from an institution established for instruction on the subject, scientific or otherwise, with which such pursuits have to deal. The nature and extent of the qualifications required must depend primarily upon the judgment of the State as to their necessity. If they are appropriate to the calling or profession, and attainable by reasonable study or application, no objection to their validity can be raised because of their stringency or difficulty. It is only when they have no relation to such calling or profession, or are unattainable by such reasonable study and application, that they can operate to deprive one of his right to pursue a lawful vocation.

"Few professions require more careful preparation by one who seeks to enter it than that of medicine. It has to deal with all those subtle and mysterious influences upon which health and life depend, and requires not only a knowledge of the properties of vegetable and mineral substances, but of the human body in all its complicated parts, and their relation to each other, as well as their influence upon the mind. The physician must be able to detect readily the presence of disease, and prescribe appropriate remedies for its removal. Everyone may have occasion to consult him, but comparatively few can judge of the qualifications of learning and skill which he possesses. Reliance must be placed

upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications. Due consideration, therefore, for the protection of society may well induce the State to exclude from practice those who have not such a license, or who are found upon examination not to be fully qualified. The same reasons which control in imposing conditions, upon compliance with which the physician is allowed to practice in the first instance, may call for further conditions as new modes of treating disease are discovered, or a more thorough acquaintance is obtained of the remedial properties of vegetable and mineral substances, or a more accurate knowledge as acquired of the human system and of the agencies by which it is affected. It would not be deemed a matter for serious discussion that a knowldge of the new acquisitions of the profession, as it from time to time advances in its attainments for the relief of the sick and suffering, should be required for continuance in its practice, but for the earnestness with which the plaintiff in error insists that, by being compelled to obtain the certificate required, and prevented from continuing in his practice without it, he is deprived of his right and estate in his profession without due process of law. We perceive nothing in the statute which indicates an intention of the Legislature to deprive one of any of his rights. No one has a right to practice medicine without having the necessary qualifications of learning and skill; and the statute only requires that whoever assumes, by offering to the community his services as a physician, that he possesses such learning and skill shall present evidence of it by a certificate or license from a body designated by the State as competent to judge of his qualifications."

Mr. Justice Brewer, in the subsequent case of Hawker v. New York, 170 U. S. 189, citing with approval the Dent case, said:

"It is insisted that within the acknowledged reach of the police power a State may prescribe the qualifications of one engaged in any business so directly affecting the lives and health of the people as the practice of medicine. * * *

"We are of opinion that this argument is the more applicable and must control the answer to this question. No precise limits have been placed upon the police power of a State, and yet it is clear that legislation which simply defines the qualifications of one who atempts to practice for the public health is something confessedly belonging to the domain of that power."

The second proposition which we advance is that the Government of the United States is one of delegated powers alone. Its authority is defined and limited by the Constitution. All powers not granted to it by that instrument are reserved to the States or the people. No rights can be acquired under the Constitution or laws of the United States except such as the Government of the United States has the authority to grant or secure. We cite in support of this contention the case of United States v. Cruikshank, 92 U. S. 542:

"Experience made the fact known to the people of the United States that they required a national government for national purposes. The separate governments of the separate States, bound together by the articles of confederation alone, were not sufficient for the promotion of the general welfare of the people in respect to foreign nations, or for their complete protection as citizens of the confederated States. For this reason the people of the

United States, 'in order to form a more perfect union, establish justice, insure domestic tranquillity, provide for the common defense, promote the general welfare, and secure the blessings of liberty' to themselves and their posterity (Const. Preamble), ordained and established the Government of the United States, and defined its powers by a constitution, which they adopted as its fundamental law, and made its rule of action.

"The government thus established and defined is to some extent a government of the States in their political capacity. It is also, for certain purposes, a government of the people. Its powers are limited in number, but not in degree. Within the scope of its powers, as enumerated and defined, it is supreme and above the States; but beyond, it has no existence. It was erected for special purposes, and endowed with all the powers necessary for its own preservation and the accomplishment of the ends its people had in view. It can neither grant nor secure to its citizens any right or privilege not expressly or by implication placed under its jurisdiction.

"The people of the United States, resident within any State, are subject to two governments—one State and the other national—but there need be no conflict between the two. The powers which one possesses the other does not. They are established for different purposes, and have separate jurisdictions. Together they make one whole, and furnish the people of the United States with a complete government, ample for the protection of all their rights at home and abroad. * * *

"The Government of the United States is one of delegated powers alone. Its authority is defined and limited by the Constitution. All powers not granted to it by that instrument are reserved to the States or the people. No rights can be acquired under the constitution or laws of the United States except such as the Government of the United States has the authority to grant or secure. All that cannot be so granted or secured are left under the protection of the States."

It has been suggested that if a federal licensing board was constituted, various States would accept the same.

The insuperable objection to this plan, it seems to us, is that the federal license under such an arrangement could not be imposed upon any State against its will.

In view of this legal situation, we are remitted, in a consideration of this question, to the view that the various States should have uniform licensing statutes, providing uniform educational, professional and personal qualifications.

OCCUPATION NEUROSES.

Published in the Cleveland *Medical Journal*, July, 1914.

Dr. Tom A. Williams of Washington, D. C., at the International Congress of Medicine, stated that a nervous breakdown supposed to be due to one's work is traceable very often to mental predispositions which have nothing to do with the work at all. Therefore compensation for industrial nervous diseases, including simstrosis, should only be made after due appreciation of the individual's makeup.

For example, a woman who had to count money in the United States Treasury ceased to be able to do so, and felt very nervous

about it because her head kept turning to the right in spite of herself. Psychological examination showed that her "neurosis" was caused by the presence of a woman with whom she had quarreled behind her and to the right.

A naval paymaster lost his power of signing checks. It was discovered that this arose from fear of their refusal. He was quickly cured.

A conductor of a freight train, after an accident, remained so nervous that he would not resume work. Examination showed that his work was distasteful and he feared it long before the accident.

Suicide and fugue may depend less upon business troubles than upon a personal cause ascertainable only by skilful psychic exploration.

DECLARTION FOR COCAINE, COCA, THEIR DERIVATIVES AND PREPRATIONS IN COMPLIANCE WITH THE REQUIREMENTS OF T. D. 33456.

Inasmuch as the indiscriminate and promiscuous use of cocaine, coca, their derivatives or preparations containing cocaine or its derivatives, is dangerous to the health of the people of the United States, and section 11 of the food and drugs act, June 30, 1906, prohibits the importation of any food or drug product into this country which is "adulterated or misbranded within the meaning of this act, or is otherwise dangerous to the health of the people of the United States * * * ," I subscribe to the following declaration as a condition precedent to the release of the merchandise enumerated therein:

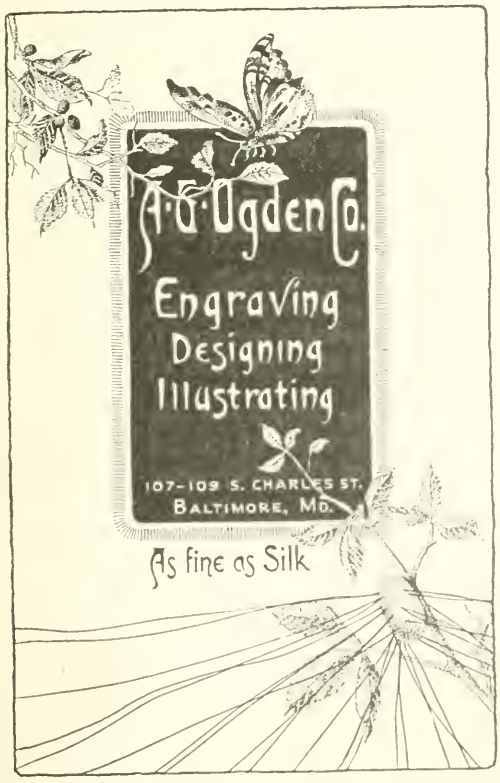
DECLARATION.

"I, [1]..... of the [2].....
..... [3].....
do solemnly and truthfully swear that the cocaine, coca, their derivatives or prepartions containing cocaine or its derivatives, more particularly described in attached invoice, bill of lading, or bill of sale, purchased from [2].....
..... by [2].....
the.....day of....., 191.., are intended in good faith for use in a manner not dangerous to the health of the people of the United States, and that I will keep, or have kept, a complete record of [4]..... in [5].....
packages of cocaine, coca, their derivatives or preparations containing cocaine or its derivatives, and will secure from each and every person, firm or corporation to whom the goods herein described, their derivatives or preparations shall be sold, in whole or in part, a declaration of this form, which declaration shall be kept on file for a period of not less than three years and be open to inspection of any properly accredited Government inspector.

"I further do solemnly and truthfully swear that each and every package of cocaine, coca, their derivatives, or preparations contain-

---

[1]Name of individual or representative.
[2]Name of individual, firm or corporation.
[3]Importer, manufacturing chemist, or wholesaler, retailer, or any other dealer in or purchaser of drugs, as the case may be.
[4]Number of pounds, pints, ounces, etc.
[5]Number.



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ing cocaine or its derivatives, more fully described in attached order, bill of lading, or bill of sale, shall bear a statement, in the form prescribed by the regulation for the enforcement of the food and drugs act of June 30,1906, of the amount of cocaine or cocaine derivatives contained therein.

"I furthermore solemnly and truthfully declare that I will make a report to the Bureau of Chemistry of the Department of Agriculture, Washington, D. C., not later than January 15 of each year of the amount of cocaine, coca, their derivatives, or preparations containing cocaine or its derivatives on hand the 1st day of January of that year, the amount imported or received during the preceding 12 months, and the disposition made thereof."

.....

.....

Declared to before me this.....day of.....191...

.....

MEDICAL MILK COMMISSIONS AND CERTIFIED MILK.

The first bulletin in the new departmental series of the United States Department of Agriculture is a contribution from the Bureau of Animal Industry, entitled "Medical Milk Commissions and Certified Milk." This is a revision of a previous bulletin on the same subject.

The organization and objects of the first milk commission are described, and the origin and meaning of "certified milk" are set forth. The word "certified" has been registered in the United States Patent Office, and may only be used by a duly organized medical milk commission.

The first milk commission was organized in 1893. Since that time over 60 commissions have been established, but nearly one-third of that number are inactive at present.

About 125 dairies are engaged in producing certified milk, and the daily production is nearly 25,000 gallons, an increase of 300 per cent. in five years. While this seems a remarkable increase, it should be remembered that only about one-half of 1 per cent. of the total milk supply of the country is certified.

While the chief demand for certified milk is for infants and sick people, it further serves to teach the public the value of careful methods in milk production and the extra cost of absolutely clean milk.

The bulletin describes the equipment and methods necessary for the production of certified milk. It is pointed out that expensive equipment is not a necessity so much as a careful and unremitting attention to details.

In 1907 the American Association of American Milk Commissions was organized. The methods and standards for the production and distribution of certified milk adopted by this association at its 1912 meeting are given in the appendix to the bulletin.

Medical and Chirurgical Faculty

OF MARYLAND.

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Camphedine—A New Iodine Preparation.

By C. A. BRYCE, M.D., Richmond, Va.

Reprint from the Southern Clinic, Nov., 1914.

THE writer has been using in his practice for a considerable time an iodine preparation put up by A. H. Robins Co., of this city, and known as Camphedine. The effects of this local remedy have been so remarkable and so satisfactory that I am impelled to call the attention of the profession to the same. I have used it under many and varied conditions, and attribute its great therapeutic value to the fortunate properties of its vehicle, which permits the remedy to enter the tissues and blood stream, as it were, by osmosis, bringing about results immediate and satisfactory. Wherever the therapeutic properties of iodine are indicated, camphedine can be relied upon, minus the disadvantages of crude iodine. It relieves local pain promptly without local irritation, on the contrary, it can be applied to denuded or burned surfaces as an anodyne.

As an antiseptic dressing, it is equal to any, and without the dangers of most of them. In all cases where prompt absorption, or lymphatic stimulation is desired, it penetrates the tissues almost as soon as it is applied to the skin. Among many cases on my notebook, I will mention one of especial interest, because I attribute the happy relief of all symptoms to the free use of camphedine.

Early in the present year I was called to see a Mrs. B——, a frail little woman suffering from a recurrent attack of appendicitis. The symptoms were plain, positive and unmistakable, and she informed me that former attend-

ants had urged the importance of operation. She was suffering severe pain, and her facial impression denoted reflex abdominal trouble. There was the soggy tumefaction over the appendix, pain and flexed limb on affected side. I put her upon a liquid diet, enjoined absolute rest and quiet and covered the right iliac quadrant with a saturated gauze of camphedine and kept it thus covered until she was entirely relieved, which occurred within 24 hours, so far as pain was concerned. In a week she was feeling entirely well, and the tumefaction and tenderness was all gone. She has had no trouble since, and I am satisfied that there are many cases of recurring appendicitis that could be cured through the alterative, absorbent and antiseptic virtues of this remedy which finds its way so readily into the diseased tissues.

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The Neurasthenic Invalid.

LIKE the poor, the neurasthenic is "always with us," and while the stress and strain of modern life and living continue, the physician will be called upon to treat the more or less chronic invalid who exhibits all sorts of bizzare symptoms, in endless and kalcidoscopic variety. It is, of course, an easy matter to advise the physician to search out and remedy the operative cause of the disorder, but it is not always as easy to do this, especially when no organic changes are discoverable. While purely symptomatic treatment may be unscientific, it is usually essential, in order to gain and retain the confidence of the patient. There is, however, one pathologic finding in a large majority of cases, and that is anemia of greater or lesser degree. In some instances this may be found to be the essential cause of the neurotic symptoms. In any event, this condition should be corrected, and for such purpose there is no better remedy than Pepto-Mangan (Gude). When a hematinic is indicated for a nervous, cranky man, or a finicky, more or less hysterical woman, Pepto-Mangan is peculiarly serviceable, as the patient cannot consistently object to the taste, which is agreeable to every one. The digestion is not interfered with in the least, constipation is not induced, and the blood-constructing effect of the remedy is prompt and certain. It is always worthy of trial, not only in the anemia of the neurasthenic invalid, but also in all conditions of blood and tissue devitalization.

A Woman's Number.

THE May issue of the Medical Review of Reviews is to be a woman's number. All the articles contributed will be from the pens of women physicians whose work has achieved national importance. With the growth of the feminist movement, the economic position of women has attracted universal attention. As medicine was practically the first profession open to women, it is only proper at this time to consider whether their entrance into the medical profession has been of benefit.

In order that women may present testimony by which they should be judged, it has been deemed advisable to give them an entire issue to present the evidence of the value of their accomplishments. In the laboratory, in the hospital, in institutions at the bedside, and in public service, women physicians have performed a valuable function. As a tribute to their earnestness, enthusiasm, modesty, energy,

perseverance and scientific acumen, the May number of the Medical Review of Reviews will be dedicated to the women physicians of America.

Glandular Tuberculosis.

THE indication for cod liver oil is so marked, of course, that the only question that will come up in regard to its use in such cases is the most suitable form in which to give it. Inasmuch as so many of these cases are in young children, the need for a palatable product at once becomes a conspicuous feature.

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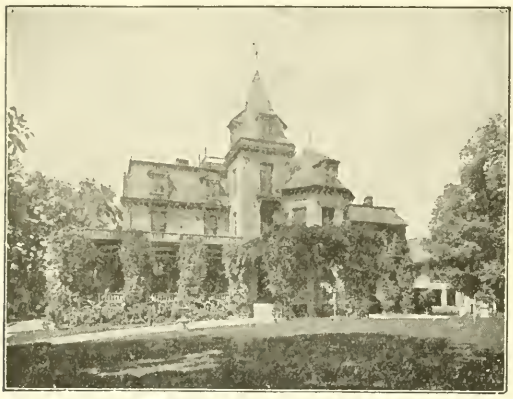

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